

State plan to individuals age 65 or older by an amount that violates the comparability of service requirements set forth in § 440.240 of this chapter.

(b) *Termination by CMS.* (1) If CMS finds, during an approved waiver period, that an agency is not meeting one or more of the requirements for a waiver contained in this subpart, CMS notifies the agency in writing of its findings and grants an opportunity for a hearing in accordance with § 441.357. If CMS determines that the agency is not in compliance with this subpart after the notice and any hearing, CMS may terminate the waiver.

(2) If CMS terminates the waiver, the following conditions apply:

(i) The State must notify recipients of services under the waiver at least 30 days before terminating services in accordance with § 431.210 of this chapter.

(ii) CMS continues to apply the APEL in § 441.354 of this subpart, but the limit is prorated according to the number of days in the fiscal year during which waiver services were offered. The limit expires concurrently with the termination of home and community-based services under the waiver.

EFFECTIVE DATE NOTE: At 57 FR 29156, June 30, 1992, § 441.356 was added. This section contains information collection and record-keeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

§ 441.357 Hearing procedures for waiver denials.

The procedures specified in § 430.18 of this subchapter apply to State requests for hearings on denials, renewals, or amendments of waivers for home and community-based services for individuals age 65 or older.

§ 441.360 Limits on Federal financial participation (FFP).

FFP for home and community-based services listed in § 440.181 of this subchapter is not available in expenditures for the following:

(a) Services furnished in a facility subject to the health and welfare requirements described in § 441.352(a) during any period in which the facility is found not to be in compliance with the applicable State requirements described in that section.

(b) The cost of room and board except when furnished as part of respite care services in a facility, approved by the State, that is not a private residence. For purposes of this subpart, “board” means three meals a day or any other full nutritional regimen. “Board” does not include meals, which do not comprise a full nutritional regimen, furnished as part of adult day health services.

(c) The portion of the cost of room and board attributed to unrelated, live-in personal caregivers when the waiver recipient lives in the caregiver’s home or a residence owned or leased by the provider of the Medicaid services (the caregiver).

(d) Services that are not included in the approved State plan and not approved as waiver services by CMS.

(e) Services furnished to recipients who are ineligible under the terms of the approved waiver.

(f) Services furnished by a provider when either the services or the provider do not meet the standards that are set by the State and included in the approved waiver.

(g) Services furnished to a recipient by his or her spouse.

§ 441.365 Periodic evaluation, assessment, and review.

(a) *Purpose.* This section prescribes requirements for periodic evaluation, assessment, and review of the care and services furnished to individuals receiving home and community-based waiver services under this subpart.

(b) *Evaluation and assessment review team.* (1) A review team, as described in paragraphs (b)(2) and (c) of this section, must periodically evaluate and assess the care and services furnished to recipients under this subpart. The review team must be created by the State agency directly, or (through inter-agency agreement) by other departments of State government (such as the Department of Health or the Agency on Aging).

(2) Each review team must consist of at least one physician or registered nurse, and at least one other individual with health and social service credentials who the State believes is qualified to properly evaluate and assess the care and services provided under the

waiver. If there is no physician on the review team, the Medicaid agency must ensure that a physician is available to provide consultation to the review team.

(3) For waiver services furnished to individuals who have been found to be likely to require the level of care furnished in a NF that is also an IMD, each review team must have a psychiatrist or physician and other appropriate mental health or social service personnel who are knowledgeable about geriatric mental illness.

(c) *Financial interests and employment of review team members.* (1) No member of a review team may have a financial interest in or be employed by any entity that furnishes care and services under the waiver to a recipient whose care is under review.

(2) No physician member of a review team may evaluate or assess the care of a recipient for whom he or she is the attending physician.

(3) No individual who serves as case manager, caseworker, benefit authorizer, or any similar position, may serve as member of a review team that evaluates and assesses care furnished to a recipient with whom he or she has had a professional relationship.

(d) *Number and location of review teams.* A sufficient number of teams must be located within the State so that onsite inspections can be made at appropriate intervals at sites where waiver recipients receive care and services.

(e) *Frequency of periodic evaluations and assessments.* Periodic evaluations and assessments must be conducted at least annually for each recipient under the waiver. The review team and the agency have the option to determine the frequency of further periodic evaluations and assessments, based on the quality of services and access to care being furnished under the waiver and the condition of patients receiving care and services.

(f) *Notification before inspection.* No provider of care and services under the waiver may be notified in advance of a periodic evaluation, assessment, and review. However, when a recipient receives services in his own home or the home of a relative, notification must be provided to the residents of the

household at least 48 hours in advance. The recipient must have an opportunity to decline access to the home. If the recipient declines access to his or her own home, or the home of a relative, the review is limited solely to the review of the provider's records. If the recipient is incompetent, the head of the household has the authority to decline access to the home.

(g) *Personal contact with and observation of recipients and review of records.*

(1) For recipients of care and services under a waiver, the review team's evaluation and assessment must include—

(i) A review of each recipient's medical record, the evaluation and reevaluation required by § 441.353(c), and the plan of care under which the waiver and other services are furnished; and

(ii) If the records described in paragraph (g)(1)(i) of this section are inadequate or incomplete, personal contact and observation of each recipient.

(2) The review team may personally contact and observe any recipient whose care the team evaluates and assesses.

(3) The review team may consult with both formal and informal caregivers when the recipient's records are inadequate or incomplete and when any apparent discrepancy exists between services required by the recipient and services furnished under the waiver.

(h) *Determinations by the review team.* The review team must determine in its evaluation and assessment whether—

(1) The services included in the plan of care are adequate to meet the health and welfare needs of each recipient;

(2) The services included in the plan of care have been furnished to the recipient as planned;

(3) It is necessary and in the interest of the recipient to continue receiving services through the waiver program; and

(4) It is feasible to meet the recipient's health and welfare needs through the waiver program.

(i) *Other information considered by review team.* When making determinations, under paragraph (h) of this section, for each recipient, the review team must consider the following information and may consider other information as it deems necessary:

§ 441.400

(1) Whether the medical record, the determination of level of care, and the plan of care are consistent, and whether all ordered services have been furnished and properly recorded.

(2) Whether physician review of prescribed psychotropic medications (when required for behavior control) has occurred at least every 30 days.

(3) Whether tests or observations of each recipient indicated by his or her medical record are made at appropriate times and properly recorded.

(4) Whether progress notes entered in the record by formal and informal caregivers are made as required and appear to be consistent with the observed condition of the recipient.

(5) Whether reevaluations of the recipient's level of care have occurred at least as frequently as would be required if that individual were served in a NF.

(6) Whether the recipient receives adequate care and services, based, at a minimum, on the following when observations are necessary (the requirements for the necessity of observations are set forth in new § 441.365(g)(3)):

(i) Cleanliness.

(ii) Absence of bedsores.

(iii) Absence of signs of malnutrition or dehydration.

(7) Whether the recipient needs any service that is not included in the plan of care, or if included, is not being furnished by formal or informal caregivers under the waiver or through arrangements with another public or private source of assistance.

(8) Determination as to whether continued home and community-based services are required by the recipient to avoid the likelihood of placement in a NF.

(j) *Submission of review team's results.* The review team must submit to the Medicaid agency the results of its periodic evaluation, assessment and review of the care of the recipient:

(1) Within 1 month of the completion of the review.

(2) Immediately upon its determination that conditions exist that may constitute a threat to the life or health of a recipient.

(k) *Agency's action.* The Medicaid agency must establish and adhere to procedures for taking appropriate ac-

42 CFR Ch. IV (10-1-06 Edition)

tion in response to the findings reported by the review team. These procedures must provide for immediate response to any finding that the life or health of a recipient may be jeopardized.

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Subpart I—Community Supported Living Arrangements Services

SOURCE: 56 FR 48114, Sept. 24, 1991, unless otherwise noted.

§ 441.400 Basis and purpose.

This subpart implements section 1905(a)(24) of the Act, which adds community supported living arrangements services to the list of services that States may provide as medical assistance under title XIX (to the extent and as defined in section 1930 of the Act), and section 1930(h)(1)(B) of the Act, which specifies minimum protection requirements that a State which provides community supported living arrangements services as an optional Medicaid service to developmentally disabled individuals must meet to ensure the health, safety and welfare of those individuals.

§ 441.402 State plan requirements.

If a State that is eligible to provide community supported living arrangements services as an optional Medicaid service to developmentally disabled individuals provides such services, the State plan must specify that it complies with the minimum protection requirements in § 441.404.

§ 441.404 Minimum protection requirements.

To be eligible to provide community supported living arrangements services to developmentally disabled individuals, a State must assure, through methods other than reliance on State licensure processes or the State quality assurance programs described under section 1930(d) of the Act, that:

(a) Individuals receiving community supported living arrangements services